



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

JT DILGER JR, MD
6718 MONTAY BAY DRIVE
SPRING, TX 77389

Respondent Name

AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-0361-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DDE"

Amount in Dispute: \$650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A copy of dispute was placed in carrier rep box on October 5, 2011 with no response to MFDR.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 11, 2010	99456-WP-W5	\$650.00	\$650.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
No Explanation of Benefits was provided by either party to the dispute.

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed the amount of \$650.00 for CPT code 99456-WP-W5 for Division ordered DD examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the documentation supports that the doctor assigned MMI. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is \$350.00. Documentation also supports the rating of the right elbow (upper extremities) with the Range of Motion (ROM) IR method per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a) and a MAR of \$300.00. The documentation also supports that additional upper extremity ratings to the nervous system were calculated per the AMA Guides to the Evaluation of Permanent Impairment, 4th Edition using Table 11, grade 2 for the nervous impairment for the sensory nerve and Table 15 3/54 for the motor nerve. There is only one body area/condition listed on the CMS-1500 which used the combined values of all these ratings. Reimbursement will be for the ROM IR of the upper extremity with a MAR of \$300.00. The combined MMI/IR MAR is \$650.00
2. Respondent has not paid any amount on CPT code 99456-WP-W5, therefore \$650.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$650.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$650.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	March 07, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.